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Measuring the professional quality of life among Latvian nurses

Kristaps Circenis^a*, Inga Millere^a, Liana Deklava^a^a*Rīga Stradiņš University, Faculty of Nursing, Dzirciema 16, Rīga LV- 1007, Latvia*

Abstract

Prolonged fatigue caused by work can cause symptoms which can influence negatively professional work quality and nurse's mental life. Professional quality of life for those providing care has been a topic of growing interest over the past twenty five years. The Professional Quality of Life Scale (ProQOL), is the most commonly used measure of the positive and negative effects of working with people. The objective of the research was to translate in Latvian and perform adaptation process of the ProQOL among nurses practicing in Latvia. All participants (500) were practicing nurses from several hospitals in Latvia. The descriptive statistic parameters of ProQOL subscales and the reliability statistical parameter Cronbach's alpha were calculated.

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Introduction

Many researchers (Figley, 2002, Najjar, Davis, 2009, Hooper, 2010, Stamm, 2010) found that nurses have been exposed to traumatic stressors and they are at risk for developing negative symptoms associated with burnout, compassion fatigue, and posttraumatic stress disorder. Professional quality of life for those providing care has been a topic of growing interest over the past twenty five years.

Professional quality of life is the quality one feels in relation to their work as a helper (Stamm, 2010). Both the positive and negative aspects of doing one's job influence ones professional quality of life. People who work in helping professions may respond to individual, community, national, and even international crises. Helpers can be found in the health care professionals, social service workers, teachers, attorneys, police officers, firefighters, clergy, airline and other transportation staff, disaster site clean-up crews, and others who offer assistance at the time of the event or later (Stamm, 2010).

The overall concept of professional quality of life is complex because it is associated with characteristics of the work environment (organizational and task-wise), the individual's personal characteristics and the individual's exposure to primary and secondary trauma in the work setting (Stamm, 2010).

Professional quality of life incorporates two aspects (Stamm, 2010): the positive (Compassion Satisfaction) and the negative (Compassion Fatigue).

Corresponding author name: * Kristaps Circenis. Tel.: +371 67 409126; fax: +371 67 471815

E-mail address: Kristaps.Circenis@rsu.lv

Compassion satisfaction Stamm (2010) described simply as "the pleasure you derive from being able to do your work well". Compassion satisfaction is a positive aspect of caring that helps to "balance out" the negative aspects of working with acutely ill or traumatized persons (Hooper et. al., 2010).

The term compassion fatigue first reflected the adverse psychosocial consequences experienced by emergency room nurses in a study exploring burnout (Joinson, 1992). Compassion fatigue has been described as the "natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping, or wanting to help, a traumatized or suffering person" (Figley, 1995).

Compassion fatigue breaks into two parts: secondary traumatic stress and burnout (Stamm, 2010). Secondary traumatic stress is a negative feeling driven by fear and work-related trauma. It is important to remember that some trauma at work can be direct (primary) trauma. Work-related trauma is a combination of both primary and secondary trauma (Stamm, 2010). Secondary traumatic stress is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1995). The person with secondary traumatic stress acquires symptoms by exposure to a traumatized individual and not from exposure to the traumatic event itself. Empathy and exposure are two central concepts in secondary traumatic stress (Beck, 2011). Secondary traumatic stress can develop suddenly and without much warning. Symptoms of secondary traumatic stress can also include a sense of helplessness and confusion and feeling isolated from supporters. These symptoms often are not connected to real causes (Figley, 1995).

Secondary traumatic stress can be viewed as an occupational hazard for persons who provide direct patient care to traumatized victims. Focusing on the nursing profession, secondary traumatic stress has been investigated with emergency department nurses, oncology nurses, forensic nurses, hospice nurses, and pediatric nurses (Beck, 2011).

Nurses need to care for themselves both personally and professionally. If nurses neglect caring for themselves and fail to recognize symptoms of secondary traumatic stress, they can compromise their ability to provide quality of care for their patients (Beck, 2011).

Maslach (1997, 2003) described burnout as consisting of three dimensions: exhaustion (including emotional), cynicism, and decreased sense of efficacy. Burnout is a long-term degradation of these dimensions caused, in part, by the chronic strain that results from insufficient resources and excessive demands or incongruence between individuals and the work they do. Unlike secondary traumatic stress, burnout develops gradually (Beck, 2011).

The signs of burnout tend to be more mental than physical. They can include feelings of: powerlessness, hopelessness, emotional exhaustion, detachment, isolation, irritability, frustration, being trapped, failure, despair, cynicism, apathy. At the same time some physical symptoms are common: headaches, sleep problems, gastrointestinal problems, chronic fatigue, muscle aches, high blood pressure, frequent colds, sudden weight loss or gain (Maslach & Leiter, 1997).

The Professional Quality of Life Scale (ProQOL), is the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events (Najjar, Davis, 2009). There are no complete studies about nurses' professional quality of life aspects situation in Latvia.

1. Objective

The objective of the research was to translate in Latvian and perform adaptation process of the Professional Quality of Life Scale (ProQOL R-V) among nurses practicing in Latvia.

2. Material and Method

Research performed using quantitative method. The instruments which used for data collection: Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Version 5 (ProQOL R-V) and demographic questionnaire.

Professional Quality of Life Scale: Compassion Satisfaction and Fatigue Version 5 (ProQOL R-V) developed by B. Hudnall Stamm. Scale consists of 3 subscales: Compassion Satisfaction, Burnout and Secondary Traumatic Stress (Stamm, 2010). Each subscale is unique, and the results of the scales cannot be combined to give a single meaningful score. The instrument includes 30 items, 10 in each scale, which are rated numerically on a 5-point Likert scale, ranging from 0 (never) to 5 (very often).

Higher scores on the Compassion Fatigue subscale (10 items) indicate the respondent is at higher risk for compassion fatigue. Higher scores on the Compassion Satisfaction subscale (10 items) indicate the respondent is experiencing better satisfaction with his or her ability to provide care (e.g., caregiving is an energy-enhancing experience, increased self-efficacy). Higher scores on the burnout subscale (10 items) indicate the individual is at risk of experiencing symptoms of burnout (e.g., hopelessness, helplessness) (Stamm, 2010).

The Professional Quality of Life Scale (ProQOL), is the most commonly used measure of the positive and negative effects of working with people who have experienced extremely stressful events. The ProQOL, originally developed in English, is translated into Finnish, French, German, Hebrew, Italian, Japanese, Spanish, Croat. European Portuguese and Russian translations are in process (Stamm, 2010).

For translation process we used one-way translation approach. Four translators independently made translation, and after discussion some adjustments were made. Final version were given to small sample of nurses, we did not receive any critical comments or suggestions. To check the reliability of the test the Cronbach's alpha was calculated for each subscale.

Descriptive statistics and Spearman's correlation were used for the evaluation of data. Two-tailed statistical significance was set at $p \leq 0.01$. The computations were carried out with SPSS for Windows, version 17.0, statistical software.

3. Results

The participants of the study were 500 practicing nurses from several hospitals in Latvia. All participants were women, age range - from 22 till 68 years (42.7; SD=8.5). The age range distribution is shown in the Figure 1.

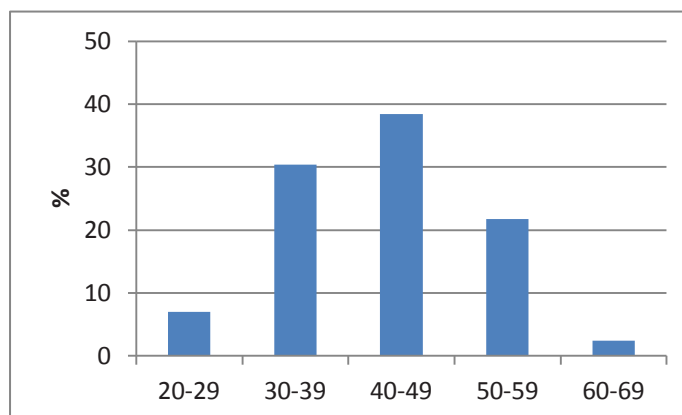


Figure 1. Age range distribution of respondents

The majority (32.4%) of respondents were working as nurses in outpatient care facilities, 30.6% in psychiatric units, 18.6% - in surgical care units, 10.6% - in operating room, and the rest of respondents (7.8%) represented the other health care fields.

Averages for Professional Quality of Life Scale subscales are shown in Table 1. The average mean for Compassion Satisfaction subscale was 37.41 (SD=7.94), for Burnout subscale mean was 22.74 (SD=6.43), for Secondary Traumatic Stress subscale mean was 19.37 (SD=6.58).

Table 1. Descriptive statistic parameters of Professional Quality of Life Scale (N=500)

	Compassion Satisfaction subscale	Burnout subscale	Secondary Traumatic Stress subscale
Minimal value	1	0	4
Maximal value	50	44	39
Mean	37.41	22.74	19.37
Standartdeviation (SD)	7.94	6.43	6.58

The reliability statistical parameter Cronbach's alpha was calculated for each subscale and the results are shown in Table 2. The highest Cronbach's alpha coefficient (0.880) was for Compassion satisfaction subscale, while for Burnout subscale it was 0.711 and for Secondary traumatic stress subscale 0.740.

Table 2. Cronbach's alpha parameters of Professional Quality of Life Scale Subscales (N=500)

Subscale	Cronbach's alpha
Compassion Satisfaction subscale	0.880
Burnout subscale	0.711
Secondary Traumatic Stress subscale	0.740

The correlation analysis using Spearman's correlation coefficient was made to find out relationship between subscales and demographic parameters. The most significant correlation (0.580; $p \leq 0.01$) was found between Burnout subscale and Secondary traumatic stress subscale. The correlation between Compassion satisfaction subscale and Burnout subscale was -0.540 ($p \leq 0.01$). We did not find any significant correlations between subscales and demographic parameters.

4. Discussion

The main benefit of the research is performed translation of the Professional Quality of Life Scale (ProQOL R-V) in Latvian and adaptation process among nurses practicing in Latvia. The descriptive statistical parameters of each subscale were calculated. We performed also comparison of our descriptive statistical parameters of each subscale with data of previously made researches (Table 3).

Table 3. Professional Quality of Life Scale subscales means and standard deviations compared with previous research (Yoder, 2010)

Research authors	Sample size (N)	Compassion Satisfaction subscale mean values and standartdeviations	Burnout subscale mean values and standartdeviations	Secondary Traumatic Stress subscale mean values and standartdeviations
Current research	500	37.41±7.94	22.74±6.43	19.37±6.58
Yoder (2010)	106	40.3±4.9	19.2±5.0	12.3±5.6
Alexander (2006)	28	39.1±5.8	20.5±4.6	13.9±5.1
Stamm (2005)	463	37.0±7.0	22.0±6.0	13.0±6.0

Compassion satisfaction subscale mean values of current study was lower than in studies of Yoder (2010) and Alexander (2006), but very close to Stamm (2006) results. It could be related with a different nurse professional role and workload in different countries across the world. Burnout subscale mean of current study was higher than all three mentioned previous studies, but the Secondary traumatic stress subscale mean was significantly higher than in all three mentioned previous studies. It could be helpful for explanation to continue data collection in different health care fields and compare results.

Cronbach's alpha reliability coefficient normally ranges between 0 and 1. However, there is actually no lower limit to the coefficient. The closer Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in the scale. Data analysis shows that in all subscales it was quite high (Cronbach's alpha coefficient for Compassion satisfaction subscale was 0.880, for Burnout subscale it was 0.711 and for Secondary traumatic stress subscale 0.740), which means good internal reliability of subscales.

5. Conclusion

As a result of present research the descriptive statistical parameters of translated Professional Quality of Life scale (version 5) subscales were obtained. The data analysis was performed including subscales reliability calculations.

Data analysis shows that Cronbach's alpha numbers in all subscales are quite high, which means good internal reliability of subscales. The confidence data of subscales are close to the original author's test reliability parameters and data shown in other studies.

It would be desirable to carry out another empirical study, selecting respondents by age, sex, length of service in occupation. This will allow for more complete conclusions.

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